Mississippi State Board of Chiropractic Examiners

P.O. Drawer 775
Louisville, Mississippi 39339
662.773.4478
662.773.4433 (FAX)

Complaint Form (**please type or print legibly**)

Your Name: _____

Your Street Address: _____

Mailing Address (if different): _____

Your Telephone: (home)_____ (work) _____

Name of person against whom you are complaining:

_____

Name of Business and Street Address of person you are filing complaint against:

_____

_____

Nature of Complaint (attach additional supporting information in complete detail):

_____

_____

_____

_____

Witnesses (provide the names, addresses, and phone numbers of your witnesses, if any):

A. Name: _____
   Address: _____
   Phone: _____

B. Name: _____
   Address: _____
   Phone: _____

C. Name: _____
   Address: _____
   Phone: _____

By signing below, I do hereby consent to appear before the Mississippi State Board of Chiropractic Examiners and any court of law to testify to the allegations set forth in the complaint and I understand that the information becomes public record once filed with the Board.

I hereby authorize the Mississippi State Board of Chiropractic Examiners to take the following actions:

1) Talk to anyone who can provide information pertaining to my complaint;
2) Access and review any and all information regarding me and my treatment.

I understand that this consent will expire six months from the date of my signature and cannot be renewed without my consent.

_____

Signature of Complainant Printed Name Date

Sworn to and subscribed before me this ____ day of _____, in the year _____.

_____

Notary Public

S E A L

County of

State of

My Commission expires: